Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## I. DISPUTE

1. a. Whether there should be reimbursement of $ 4,736.00 for date of service 08/15/01.

   b. The request was received on 01/15/02.

## II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 11/15/01
   b. HCFA(s)
   c. TWCC 62 forms and Medical Audit summary dated 10/26/01
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 04/09/02
   b. Peer Review dated 10/02/01
   c. Initial Response to the Request to the Medical Dispute dated 01/18/02
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The carrier indicates the Request for Medical Dispute Resolution was received by them on 03/26/02, therefore, the response is considered timely. There is no Notice of Medical Dispute in this Commission case file.

4. There is no Notice of Medical Dispute reflected as Exhibit III in this Commission's case file.

## III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated 11/05/01 that, "My charges for codes 15732, 64708,23405 [sic] and 24310 were denied as [sic] 'included in basic allowance for another procedure.'….I have explained my procedures and the reasons as to why I billed in the order that I did. These procedures are separate procedures and should be reimbursed accordingly."

2. Respondent: The respondent's representative states in the correspondence dated 04/09/02 that, "The…received notification of the request for dispute resolution from Dr…, M.D. on 3/26/02….the requestor billed the carrier for additional CPT Codes representing services which were global to the primary procedure and purpose of the outpatient stay….The result of the peer review, dated 10/2/01, was that based on the peer reviewer's knowledge, the service itself (beyond the preauthorized service) was not 'recorded in any textbooks of orthopaedic surgery,' and that the separate remaining unpaid charges did not warrant additional reimbursement…"

## IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 08/15/01.

2. The peer review dated 10/02/01 stated, "Dr…performed a brachial plexus neurolysis. This was pre-authorized….This was typified under code 64713 and exactly describes the procedure in question….It is my professional opinion that code 64713 exactly typifies…what this operative procedure details. Hence code 467413 [sic] with an [sic] MFG of $1102 is the appropriate descriptive code. It would be my medical opinion that code [sic] 15732, 64708, 23405, 24310, 21700, and even 64772 are superfluous and should be considered global."

3. The carrier denied the billed charges by denial code, "G – REIMBURSEMENT FOR THIS PROCEDURE IS INCLUDED IN THE BASIC ALLOWANCE OF ANOTHER PROCEDURE." A medical audit dated 10/26/01 states, "Reimbursement for this procedure is included in the basic allowance for another procedure." Since there are no other EOB(s) or medical audits, the Medical Review Division's decision is rendered based on denial codes submitted to the provider to the date the dispute was filed.

4. On the Table of Disputed Services, the provider included CPT code 64713 which was reimbursed at $647.50; CPT code 21700 which was reimbursed at $328.50; and CPT code 64772 which was reimbursed at $300.00. These codes are not in dispute.

5. According to the Global Service Data Orthopaedic for Surgery, CPT code 64713 **is considered global**. The insurance carrier paid the provider $647.50 for CPT code 64713**,** therefore, **re-payment of $647.50** is recommended to the insurance carrier.

6. The following table identifies the disputed services and Medical Review Division's rationale:

| DOS | CPT or Revenue CODE | BILLED | PAID | EOB Denial Code(s) | MAR$ (Maximum Allowable Reimbursement) | REFERENCE | RATIONALE: |
|---|---|---|---|---|---|---|---|
| 08/15/01 | 15732 | $2,124.00 | $0.00 | G | $2,124.00 | MFG SGR (D) (1) (a); Global Service Data for Orthopaedic Surgery January, 1994; CPT descriptor | "100% of the MAR for the primary procedure, (major procedure reflecting the greatest value)" should be reimbursed. According to the Global Service Data for Orthopaedic Surgery, CPT code 15732 is not considered a global procedure. Reimbursement of **$2,124.00** is recommended. |
| 08/15/01 | 64708 | $508.00 | $0.00 | G | $1,012.00 | MFG SGR (D) (1) (b); Global Service Data for Orthopaedic Surgery January, 1994; CPT descriptor | "50 % of the MAR for secondary or subsequent procedures…" should be reimbursed. According to the Global Data Service Data for Orthopaedic Surgery, CPT code 64708 is considered a global procedure. **No** reimbursement is recommended. |
| 08/15/01 | 23405 | $430.00 | $0.00 | G | $860.00 | MFG SGR (D) (1) (b); Global Service Data for Orthopaedic Surgery January, 1994; CPT descriptor | "50 % of the MAR for secondary or subsequent procedures…" should be reimbursed. According to the Global Service Data for Orthopaedic Surgery, CPT code 23405 is not considered a global procedure. Reimbursement of **$430.00** is recommended. |
| 08/15/01 | 24310 | $400.00 | $0.00 | G | $506.00 | MFG SGR (D) (1) (b); Global Service Data for Orthopaedic Surgery January, 1994; CPT descriptor | "50 % of the MAR for secondary or subsequent procedures…" should be reimbursed. According to the Global Service Data for Orthopaedic Surgery, CPT code 24310 is not considered a global procedure. Reimbursement of **$253.00** is recommended. |
| 08/15/01 | 64713 | $647.50 | $647.50 | Paid | $1,315.00 | MFG SGR (D) (1) (b); Global Service Data for Orthopaedic Surgery January, 1994; CPT descriptor | "50 % of the MAR for secondary or subsequent procedures…" should be reimbursed. According to the Global Service Data for Orthopaedic Surgery, CPT code 64713 is considered a global procedure, therefore**, re-pay of $647.50** is recommended to the insurance carrier. |
| **Totals** | | $3,460.00 | $0.00 | | | | The Requestor **is** entitled to reimbursement in the amount of **$2,159.50** ($2,124.00 + $430.00 + $253.00 24310) - $647.50 = $2,159.50) |

The above Findings and Decision are hereby issued this 21st day of May 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm

## VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $2,159.50 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 21st day of May 2002.

Carolyn Ollar, B.A., RN
Medical Dispute Resolution Officer
Medical Review Division

CO/dmm

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.